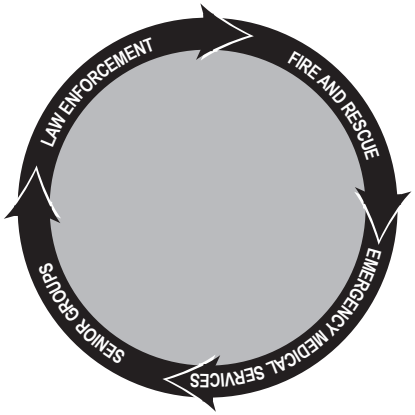
The Yellow Dot Program



Personal Information

Name _____ Age_____

Address_____

City/St/Zip _____

Home Ph. (_____) _____

Cell Ph. (_____) _____

Physicians

Name _____

City/State _____

Office Ph. (_____) _____

Name _____

City/State _____

Office Ph. (_____) _____

ADECA
Alabama Department of Economic and Community Affairs

Photo

Please Note: The Yellow Dot Program acts as facilitator only. All information contained herein is supplied by and is the sole responsibility of the participating person listed.

Participant's Name

(See back panel for Personal Information, see inside for Contacts, Medical Information & Medications)

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Date _____

(Update the Date whenever any information is changed)

Please fill in information in pencil to facilitate updates as information changes. Include Area Codes with all phone numbers. Update every 6 months at time change.

Emergency Contact Information

Name _____

Address_____

City/St/Zip _____

Home Ph. (_____) _____

Cell Ph. (_____) _____

Work Ph. (_____) _____

Name _____

Address_____

City/St/Zip _____

Home Ph. (_____) _____

Cell Ph. (_____) _____

Work Ph. (_____) _____

Medications (Generic Name)

_____

_____

_____

_____

_____

_____

_____

Hospital Preference

_____

(Does not guarantee transport to Hospital Preference)

Blood Type _____

Medical Conditions/Recent Surgeries

(Check All That Apply)

- ☐ NO KNOWN MEDICAL CONDITIONS
- ☐ Abnormal EKG
- ☐ Adrenal Insufficiency
- ☐ Angina
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer: Type
- ☐ Cardiac Dysrhythmia
- ☐ Clotting Disorder
- ☐ Coronary Bypass Graft
- ☐ COPD/Emphysema
- ☐ Dementia / Alzheimer's
- ☐ Diabetes/Insulin Dependent
- ☐ Eye Surgery
- ☐ Fractures
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Hearing Impaired
- ☐ Heart Valve Prosthesis
- ☐ Hemodialysis
- ☐ Hemolytic Anemia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ Internal Defibrillator
- ☐ Kidney Problems
- ☐ Laryngectomy
- ☐ Leukemia
- ☐ Lymphomas
- ☐ Malignant Hyperthermia
- ☐ Myasthenia Gravis
- ☐ Pacemaker
- ☐ Pregnant:Date Due ____
- ☐ Renal Failure
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Vision Impaired
- ☐ Other: List Below

_____

_____

_____

Allergies: (Check All That Apply)

- ☐ NO KNOWN ALLERGIES
- ☐ LATEX
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Demorol
- ☐ Insect Stings
- ☐ Lidocaine
- ☐ Morphine
- ☐ Novocaine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ X-Ray Dyes
- ☐ Xylocaine
- ☐ Other: List

_____

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